MATERNITY OUTPATIENT MEDICAL SERVICES ENROLLMENT NOTICE

Michigan Department of Community Health
Medical Services Administration

Today's Date
/ /
Guarantee Letter No.
M

INSTRUCTIONS: Complete form, send one copy to MDCH/ MOMS, PO Box 30479, Lansing, MI 48909-7979 and retain one copy at the Local Health Department.

APPLICANT INFORMATION:

Medicaid ID #	**O R**	Date Applied for Medicaid	Date of Birth (MM/DD/YYYY)	Social Security Number
		/ /	/ /	- -

Last Name (as it appears on Medicaid application)	First Name	Middle Name

Address

City	State	ZIP

Do you have private Health Insurance other than Medicaid?	If YES, please list name of the Insurance Company.
☐ **NO** ☐ **YES**	
Expected Date of Delivery (Mandatory for Enrollment)	Actual Date of Delivery (If Pregnancy has ended)
/ /	/ /

HEALTH AGENCY INFORMATION:

County of Agency	Contact Person Name	Phone Number
		( ) -

Name of Local Health Agency

Address

City	State	ZIP

Comments/ Updates

AUTHORITY: Appropriations Act. **COMPLETION:** Is Voluntary, but this information is required to enroll in this program.	The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

ELIGIBILITY INFORMATION: *(For MDCH / MSA Use Only)*

Effective Date of Eligibility	Ending Date of Eligibility	Date of Full MA Eligibility	Eligibility Code			
			F	**P**	**ESO**	

DISTRIBUTION 1 Copy - MDCH
1 Copy - Local Health Department